

**Subject:** FW: Re- car

**Date:** Monday, May 22, 2017 at 2:01:31 PM Central Daylight Time  
**From:** Jean Hecht  
**To:** Megan Lengerman

**Office of Administration**  
Commissioner's Office

**"Request for Preauthorization for Other Services"**

Program: **Alternatives to Abortion**

Contractor: Nurses for Newborns  
Subcontractor: N/A

Please enter below the information for each item/service to be purchased. List the date of purchase, item to be purchased, cost for the item, and the justification. Items must be approved **before** purchased/provided to be reimbursed.

*Client Name:* \_\_\_\_\_ *Date Enrolled:* \_\_\_\_\_  
03/10/2017

Proposed Purchase Date	Item	Total Cost (include formal estimate from provider of services)	Justification, include other sources of funding that have been attempted
June 5, 2017	Car Payment	\$411.00	This is the client's only mode of transportation. There is no public transportation in St. Charles County. The client's mother has helped with payments in the past but is unable to at this time. She has also called some churches to see if they can help but they do not have the funding at this time either.
<b>AMOUNT TO BE REIMBURSED\$</b>		\$411.00	<u>\$400.00</u>

*Please return to Alternatives to Abortion Program Manager, State of Missouri - Office of Administration, Commissioner's Office, State Capitol Building, Room, 125, Jefferson City, MO 65101. May be faxed to 573/751-1212 or emailed to [emily.kraft@oa.mo.gov](mailto:emily.kraft@oa.mo.gov) <mailto:Karen.Schenk@dhss.mo.gov> by the Contractor only!*

Thank you.

Authorized person requesting purchase:

Approved for purchase: Emily Kraft Date 5/23/17

Purchase denied: \_\_\_\_\_ Date \_\_\_\_\_

Reason for denying purchase: \_\_\_\_\_



Questions?

Visit [ally.com/auto](http://ally.com/auto) or call 888-925-ALLY (2559)

Statement reflects payment(s) received through: 05/19/17

**Account Summary****Next Payment**

Due Date: 06/10/17  
Monthly Amount: \$411.23

**Past Due Payments**

Total: ..... \$411.23 Total: ..... \$0.00 Total: ..... \$0.00

**STATEMENT TOTAL: \$411.23**

Due Date	Scheduled Payment	Date Paid	Unpaid Balance	Finance Charge	Late Charge	Other Charge	Total Paid
05/10/17	411.23	04/12/17	143.79	267.44	0.00	0.00	411.23

**Account Information****Important Account Message**

REMAINING UNPAID BALANCE \$14,889.13. THIS AMOUNT DOES NOT INCLUDE FINANCE CHARGES AND OTHER UNPAID AMOUNTS. PLEASE CALL US FOR YOUR PAYOFF.

**Don't Want to Mail Your Payment? We have Options:**

- Automatic Payments** – Allows your payment to be conveniently transferred from your checking or savings account to Ally, at no cost to you. Please visit [ally.com/auto](http://ally.com/auto) for more information.
- Online Payments and Billing Statements** – Register for Ally Online Services at [ally.com/auto](http://ally.com/auto), add your account, then schedule one-time payments at your convenience or go green with e-statements, at no cost to you.
- Payments by phone or payments online by debit cards** – To hear available options call 888-925-2559. A third party service provider fee may apply.

**Contact Information:** You can reach us by visiting [ally.com/auto](http://ally.com/auto) or call us at 888-925-ALLY(2559)

Do not send cash or post-dated checks. All checks will be processed upon receipt. Make checks payable to ALLY.

Return the portion below with your payment to the Payment Processing Center address below

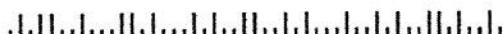
0000-0000



PO BOX 380902  
BLOOMINGTON MN 55438-0902

DUE DATE: 06/10/17  
ACCOUNT NUMBER: XXXXXXXXXX  
STATEMENT TOTAL: \$411.23  
TOTAL AMOUNT PAID: \$ XXXXXXXXXX

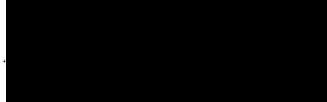
PAYMENT PROCESSING CENTER  
PO BOX 9001951  
LOUISVILLE KY 40290-1951



# ALTERNATIVES TO ABORTION PROGRAM

## Assistance Request

*This form is to be completed by an NFN Nurse ONLY and must be completed entirely for timely approval and submission.*

DATE: 5/15/17 CLIENT NAME: 

*The above named client is requesting assistance through NFN's ATA Program for the following:*

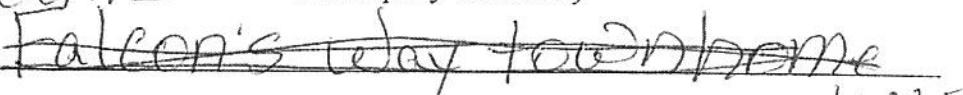
Rent

(if new request, a W-9 and Lease MUST accompany this form)

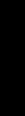
Utility

(if Ameren, provide account number and account holder's name; if Laclede, provide bill)

Payment Process Center

Landlord/Utility/Other NAME: 

BILL TOTAL: \$ 411

AMOUNT YOU ARE PAYING: \$ 

AMOUNT REQUESTED: \$ 411

0

(list at least three):

1. 211
2. \_\_\_\_\_
3. \_\_\_\_\_

Agency Representative: \_\_\_\_\_

Agency Representative: \_\_\_\_\_

Agency Representative: \_\_\_\_\_

Payment Process Center PO Box 9001951 Louisville, KY 40290

*I understand this is a one-time payment. This assistance is intended to assist you in the delivery of a healthy baby or in keeping your child on target developmentally. I have completed a Budget Form and Individualized Pregnancy Continuation Plan (IPCP) with my nurse in order to ensure my ability to pay this bill in the future.*

(client signature)

(date)

(RN signature)

(date)

IPCP Completed/Submitted: \_\_\_\_\_ (initial)

Budget Form Completed: \_\_\_\_\_ (initial)

Date Received: \_\_\_\_\_ Date Pledged/Submitted for Payment: \_\_\_\_\_

